Certification of Health Care Provider - Employee's or Family Member's Serious Health Condition

Instructions:

Use this form to obtain physician or medical practitioner certification that the employee or a family member is disabled due to a "serious health condition," as defined in *Attachment A: Definitions*. While you are not required to use this form, you may not ask the employee to provide more information than required under the Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA).

Due to the confidential nature of this information, use this form as follows:

1. Add the company name and contact in Section I and provide the employee with a copy of his/her job description along with this form. Make sure the job description identifies the essential functions of the employee's position.
2. Have the employee complete the rest of Section I.
3. Instruct the employee to:
    a. Give the job description and *Health Care Provider Certification* section of the form (Section II) to the health care provider. Make sure to also provide the health care provider with Attachment A.
    b. Complete and sign the *Employee's Statement Regarding Seriously Ill Family Member* section (Attachment B) if the employee is requesting family leave to care for a seriously ill family member, and provide this attachment under separate cover to the health care provider (not the employer).
    c. Have the health care provider complete and sign the *Health Care Provider Certification* section.
    d. Sign and return the *Health Care Provider Certification* section to you for documentation purposes (after it is completed by the health care provider). You must give the employee at least 15 calendar days to return the form.
4. File the completed *Health Care Provider Certification* section in the employee's confidential medical file. *Employers are generally required to maintain records and documents dating to medical certifications, recertifications or medical histories of employees or employees' family members created for FMLA/CFRA purposes in separate files/records from the usual personnel files in accordance with 29 CFR 1630.14(c)(1), if the American Disabilities Act applies, and in accordance with 29 CFR 1635.9, if the Genetic Information Nondiscrimination Act applies.
5. Retain a copy of this form in your records for four years.

▲ Click above to insert your company logo

Replace this text with company name or delete to leave blank

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***IMPORTANT NOTE:** The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) and the federal Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by law. **To comply, we are asking that you not provide any genetic information when responding to this request for medical information.** "Genetic information," as defined by CalGINA and GINA, includes information about the individual's or the individual's family member's medical history, genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic information" does not include information about an individual's sex or age.

SECTION I - EMPLOYER

Company Name _____

Company Contact _____

Attach a copy of the employee's job description and the essential job functions of the employee's position to this form.

Instructions for the employee: The law permits us to require that you submit a timely, complete and sufficient medical certification to support your request for FMLA/CFRA leave to care for yourself or a covered family member with a serious health condition. If requested by your employer, your response is required to obtain the benefit of Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA) protections. Failure to provide a complete and sufficient medical certification may result in a denial of your request. You have **15 calendar days** to return this form to the company. If extenuating circumstances prevent you from returning this certification in a timely manner, please contact _____ .

_____ _____

Employee Name | Employee Contact Number

If the request is to care for a family member:

_____

Name of the family member/patient for whom you will provide care

Relationship of family member to you:

- ☐ Child (if the child is under the age of 18, or over the age of 18, if the child is incapable of self-care due to a physical or mental disability), parent or spouse. **(CFRA only, FMLA only or CFRA/FMLA depending on eligibility and leave availability)**
- ☐ Child (if the child is an adult capable of self-care), parent-in-law, grandparent, grandchild, sibling, domestic partner or someone else with a blood or family-like relationship with the employee ("designated person"). **(CFRA only)**

If the request is to care for a family member, please complete Attachment B and **provide to the health care provider**, not your employer.

I certify that the information I have provided is true and correct.

_____ _____

Employee Signature | Date

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SECTION II - HEALTH CARE PROVIDER

I**nstructions for the Health Care Provider:** The employee listed above has requested leave under the FMLA/CFRA to care for himself/herself or for your patient who is a family member or "designated person" listed above. Please answer fully and completely all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Limit your responses solely to the condition for which the patient needs leave. Please be sure to sign the form. **PLEASE DO NOT DISCLOSE THE UNDERLYING DIAGNOSIS, INCLUDING ANY GENETIC INFORMATION*, WITHOUT THE CONSENT OF THE PATIENT.** Do not provide information about genetic tests, as defined in 29 CFR 1653.3 (f), genetic services, as defined in 29 CFR 1635.3 (e), or genetic information, as defined by CalGINA or GINA. Please be sure to sign the form.

1. Date medical condition or need for treatment commenced: _____
2. Probable duration of medical condition or need for treatment: _____
3. *Attachment A: Definitions* describes what is meant by a "serious health condition" under both the federal FMLA and California CFRA. Does the patient's condition qualify as a serious health condition?
   ☐ Yes ☐ No
4. If the certification is for the serious health condition of the employee, please answer the following:
   a. Is the employee able to perform work of any kind?
      ☐ Yes ☐ No (If "no" skip next question)
   b. Is the employee unable to perform any one or more of the essential functions of the employee's position? (Please answer after reviewing the attached job description provided by the employee that includes the essential functions of the employee's position.)
      ☐ Yes ☐ No

      If yes, to 4b, please identify the job functions the employee is unable to perform.

      _____

      _____
5. If the certification is for the care of the employee's family member or "designated person," please answer the following:
   a. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation needs or the provision of physical or psychological care?
      ☐ Yes ☐ No
   b. After review of the signed *Employee's Statement Regarding Seriously Ill Family Member* (Attachment B), does the condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging for third-party care for the family member.)
      ☐ Yes ☐ No
6. Estimate the period of time the employee will need care or during which the employee's presence would be beneficial to participate in care for the employee's family member:

   _____

***** See the "Important Note" on page 1 of this form. CalGINA and GINA prohibit employers from obtaining genetic information. **To comply, we are asking that you not provide any genetic information when responding to this request for medical information.**

7. Please answer the following questions only if the employee is asking for intermittent leave or a reduced work schedule:

Yes No

☐ ☐ Intermittent Leave: Is it medically necessary for the employee to be off work on an intermittent basis due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the estimated frequency of the employee's need for intermittent leave due to the serious health condition and the duration of such leaves (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

☐ ☐ Reduced Schedule Leave: Is it medically necessary for the employee to work less than the employee's normal work schedule due to the serious health condition of the employee, family member or "designated person"?

If yes, please indicate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day; _____ day(s) per week, from _____ through _____

☐ ☐ Time Off for Medical Appointments or Treatment: Is it medically necessary for the employee to take time off work for doctor's visits or medical treatment, either by the health care practitioner or another provider of health services?

If yes, please indicate the estimated frequency of the employee's need for leave for doctor's visits or medical treatment and the time required for each appointment, including any recovery period:

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per appointment/treatment

_____ _____
Signature of Health Care Provider Date

_____ _____
Signature of Employee Date

Physician or Practitioner Information:

_____
Physician's or Practitioner's Name

_____
Business Address

_____ ____ _____-_____
City State Zip

(____) ____-_____
Telephone

RETURN THIS FORM TO THE PATIENT. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.

Form adapted for California use from CFRA Regulations (2 CCR sec. 11097) and CRD-E11P-ENG (1/23) and U.S. Department of Labor WH-380-E and WH-380-F Revised June 2020 (OMB Control Number 1235-0003 Expires: 06/30/2026)

Attachment A: Definitions

A "serious health condition" means an illness, injury (including, but not limited to, on-the-job injuries), impairment, or physical or mental condition of the employee or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, domestic partner, or someone else with a blood or family-like relationship with the employee ("designated person") of the employee that involves either inpatient care or continuing treatment, including, but not limited to, treatment for substance abuse. A serious health condition may involve one or more of the following:

HOSPITAL CARE

Inpatient care in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care. A person is considered an "inpatient" when a health care facility formally admits the person to the facility with the expectation that the person will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

ABSENCE PLUS TREATMENT

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

1. Treatment two or more times by a health care provider (for FMLA only, the two treatments must occur within 30 days ***), by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
2. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

For FMLA only, the employee's first treatment must occur within 7 days of first day of incapacity. ***

PREGNANCY

Any period of incapacity due to pregnancy or for prenatal care.
(Note: An employee's own incapacity due to pregnancy is covered as a serious health condition under FMLA but not under CFRA.)

CHRONIC CONDITIONS REQUIRING TREATMENT

A chronic condition, which:

1. Requires periodic visits (for FMLA ONLY, periodic means at least two times per year ***) for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
3. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke or the terminal stages of a disease.

MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

*** California law does not include these time limitations. If a leave is FMLA/CFRA, follow the California law without these time limitations.

Attachment B: Employee's Statement Regarding Seriously Ill Family Member

To be completed and signed by the employee needing family leave to care for a seriously ill family member. **Employee should provide this section to the health care provider under separate cover. This information is NOT to be provided to the employer.**

If you are seeking leave to care for a seriously-ill family member, please provide a description of the care you will provide for your family member (include an estimate of the time period during which this care will be provided and a schedule if leave is to be taken intermittently or on a reduced work schedule):

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information I have provided is true and correct.

_____ _____

Signature of Employee Date